HOUSE OF LORDS

SESSION 1997–98
3rd REPORT

SELECT COMMITTEE ON
SCIENCE AND TECHNOLOGY

CLINICAL ACADEMIC CAREERS

REPORT WITH EVIDENCE

Ordered to be printed 3rd December 1997

LONDON: THE STATIONERY OFFICE
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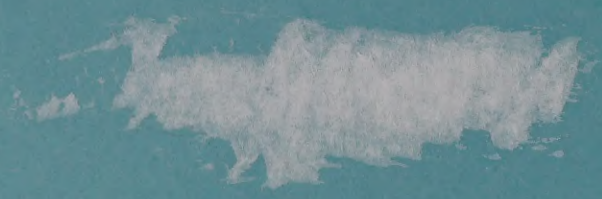
HL Paper 47



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Clinical medicine
Medical research personnel
career development

CONTENTS

THIRD REPORT

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By the Select Committee appointed to consider Science and Technology.

ORDERED TO REPORT

CLINICAL ACADEMIC CAREERS

1. The United Kingdom has a high reputation for medical and dental practice, teaching and research. These three things are interdependent, and come together in the person of the "clinical academic": a doctor or dentist who divides his or her time between teaching and research in a university medical or dental school, and providing clinical services through the NHS.

2. In 1995 this Committee reported on *Medical Research and the NHS Reforms* (3rd Report 1994–95, HL Paper 12), expressing serious concern about the state of clinical academic medicine. We found recruitment and retention to be poor; we ascribed this in large measure to increasing and conflicting loads of service provision, administration and teaching, and we anticipated that the "Calman" reforms to specialist training might make matters even worse. We concluded, "The disincentives to an academic medical career are now so great as to warrant an immediate enquiry in their own right".

3. The Government did not share our view. However the Committee of Vice-Chancellors and Principals did, and commissioned an independent task force, chaired by Sir Rex Richards (Vice-Chancellor of Oxford University 1977–81), to conduct the enquiry which we proposed. Their report, *Clinical Academic Careers*, was published in July. It concludes, "there is a potentially serious problem ... Academic medicine and dentistry are suffering the fate of any servant with two masters; in this case the NHS and the universities ... staff in each work at a higher intensity with increased demands and expectations on them, and often with an increased administrative load ... it often appears that clinical academics work under greater pressures and receive less reward than NHS doctors and dentists".

4. The task force make numerous recommendations, addressed variously to the universities, the Higher Education Funding Councils and the education departments; NHS Trusts, the NHS Executive and the health departments; the medical Royal Colleges and other professional bodies; and the charities and other funders of research. In particular, they recommend a range of mechanisms to protect time for research; to mitigate the material disadvantages of academic medicine compared with purely clinical practice, and of academic general practice compared with other disciplines; and to improve co-ordinated management in university hospitals and medical schools. They recommend further work on the organisation and funding of dental education and research.

5. On 3rd November, Sir Rex and some of the members of his task force met us to present their report and discuss its recommendations. The record of that meeting is appended to this report. We inspired the task force, though we did not commission it; and we congratulate Sir Rex and his colleagues on the work which they have done. We are persuaded more than ever that there is a genuine threat to academic medicine in the United Kingdom, and therefore to health care as a whole.

6. Unless action along the lines recommended can be taken, the situation will get worse. Many of the actions proposed are essentially cost-free; but adoption of others would require the allocation of additional resources which have not yet been quantified. Such allocations would of course depend on hard choices being made about priority between competing claims for both health and

higher education, and many other problem areas in both sectors would rightly wish to be involved in the debate.

7. We draw particular attention to the recommendation that "more work should be done to explore the concept of the 'University Hospital NHS Trust'". Any consideration of the management structure of teaching hospital Trusts should also cover the management structure of the large number of Trusts which, though not formally teaching hospitals, have an increasing involvement with one or more medical schools. The question whether such Trusts would benefit from an additional Non-Executive Director, nominated by the relevant university, deserves examination. Any of these proposed changes to management structures would require primary legislation; however this might be done by including the provision in any National Health Service Bill.

8. We welcome a joint initiative by the NHS Executive and the Higher Education Funding Council for England, announced in June in a letter to Vice-Chancellors, Deans of Medical and Dental Schools, NHS Regional Directors and NHS Regional Directors of R&D. The letter says,

> "The partnership between the NHS and the university sector is unparalleled and we both recognise the importance of ensuring that the funding policies of one sector take account of the needs of the other. We have therefore agreed to schedule regular meetings and to address particular issues through specific task groups. The first task group to be set up should consider the best ways to handle health services research in the next Research Assessment Exercise (RAE). A second task group, which will be established when the report of Sir Rex Richards' Task Force on Clinical Academic Careers is available, will examine more closely the links between teaching, research and patient care and their implications for the RAE."

9. This is welcome evidence that the Government acknowledge the problem, or at least an important part of it. More such evidence is to be found in a letter to us from Mr Alan Langlands, Chief Executive of the NHS, which is appended to this Report. We now look for action, to safeguard the future of health care in the United Kingdom. We intend to keep this matter under review.

APPENDIX 1

Members of the Select Committee

Lord Carmichael of Kelvingrove
Lord Craig of Radley
Lord Dainton
Lord Dixon-Smith
Lord Flowers
Lord Gregson
Baroness Hogg
Lord Howie of Troon
Lord Jenkin of Roding
Lord Kirkwood
Lord Perry of Walton
Lord Phillips of Ellesmere (Chairman)
Baroness Platt of Writtle
Lord Porter of Luddenham
Lord Soulsby of Swaffham Prior
Lord Tombs
Lord Winston

APPENDIX 2

Letter from Mr Alan Langlands, Chief Executive of the NHS

Thank you for your letter of 13 November. I am content for the Select Committee's forthcoming report on clinical academic careers to quote from the letter of 26 June 1997.

I believe that the steps Professor Fender and I have taken to ensure good liaison between HEFCE and the NHS over future research assessment exercises and in particular, how health services research is handled are very important. I am pleased that the Select Committee has taken note of our intervention.

You may also wish to be aware that since Sir Rex Richards began his work there have been a number of other significant developments.

In response to concerns over the implementation of the Calman reforms to higher specialist training and their effects on clinical academic medicine, the Department of Health has issued a special supplement to the *Guide to Specialist Registrar Training*. This provides additional information on the opportunities and flexibilities that exist under the new training arrangements. It has been well received by the clinical academic community and will be incorporated into a revised version of the Guide which we expect to publish early in the New Year.

The Select Committee will also be aware of clinical academics' longstanding concern about pay parity with NHS colleagues. This is referred to in the draft report. Last year, in response to this concern, the Department for Education and Employment acted to ensure that arrangements for clinical academics pay were placed on a firmer footing. Additional funds were made available for 1996/97 to give, amongst other things, clinical academics the same pay award as their NHS colleagues. In 1997/98 HEFCE will require all universities and colleges to meet the additional costs for medical and dental schools arising from any pay increase awarded by the Government to NHS clinicians.

Liaison between the universities and the NHS is also being strengthened including a joint initiative with HEFCE to identify and disseminate good practice, highlighting and promoting examples of good NHS/university partnership at local level.

An Academic and Research Sub-group has been established as part of the Department of Health's Advisory Group on Medical Education Training. This is chaired by the Chief Medical Officer, Sir Kenneth Calman and provides a forum for the academic and research community to discuss matters of mutual concern with senior officials in the Department. This sub-group was pivotal in producing the supplement to the Guide to Specialist Registrar Training and is due to meet again in early December.

Finally, as part of our efforts to strengthen the enduring partnership between the NHS and the universities, senior staff of the NHS Executive meet at regular intervals with members of the Council of Vice-Chancellors and Principals. We are also forging closer working links with the Council of Heads of Medical Schools.

I hope that the Select Committee will find this additional information useful. Liaison arrangements continue to improve and the Department of Health is firmly committed to an approach which is sensitive and receptive to the concerns of clinical academic staff.

24 November 1997

MINUTES OF EVIDENCE

TAKEN BEFORE THE SELECT COMMITTEE ON SCIENCE AND TECHNOLOGY

MONDAY 3 NOVEMBER 1997

Present:

Butterfield, L.
Jenkin of Roding, L.
Flowers, L.
McFarlane of Llandaff, B.
Perry of Walton, L.
Phillips of Ellesmere, L.
Selborne, E.
Walton of Detchant, L. (Chairman)

Examination of Witnesses

SIR REX RICHARDS, FBA, FRS, Chairman, CVCP Task Force on Clinical Academic Careers, PROFESSOR SIR KEITH PETERS, FRCP, FRS, Regius Professor of Physic, University of Cambridge, PROFESSOR COLIN SMITH, BDS, PhD, LDS, FRCPath, Dean of Dental Studies, University of Sheffield, SIR DEREK ROBERTS, Feng, FInstP, FRS, Provost, University College London, and DR ERIC SIDEBOTTOM, BM, DPhil, Secretary of the CVCP Task Force, were called in and examined.

Chairman

1. Good morning, gentlemen. Thank you very much for coming. May I, at the outset, just for the record, remind everyone that, of course, the enquiry upon which you, Sir Rex, and your colleagues embarked was as a consequence of the enquiry of the Select Committee and its Sub-Committee which examined medical research in the NHS in the light of reforms, and that Committee made a recommendation that, because of the problems encountered by academic clinical medicine, the Government should embark upon a major enquiry. That was not accepted by the Government but happily the CVCP took up the baton and they asked you to chair this enquiry; we are very grateful to you and your colleagues on the Task Force for your detailed report. This morning is intended, first, to explore with you some of the major recommendations in that report and, secondly, to discover the extent to which the CVCP and other bodies are embarking upon attempts to implement it. So, Sir Rex, I wonder if you would highlight the main conclusions of your report?

(*Sir Rex Richards*) You will have seen that the report has attempted to confirm many of the fears that you expressed in your report. In order to do that we sent a very detailed questionnaire to the deans of all the medical and dental schools and we are extremely grateful to them. All of them filled in our questionnaire and gave us an enormous amount of information, which is aggregated in the report. I did give an undertaking to all the deans that we would not disclose information about individual medical or dental schools without their permission, and that is why the data are aggregated in the report. I think the main conclusion is summarised at the very end of the report. May I read that paragraph to you?

2. Yes, please.

(*Sir Rex Richards*) "Throughout our enquiries we have been struck by the extent to which pressures of the NHS service conflict with needs of clinical researchers and teachers to commit the main part of their time and energy to research. Since the 1991 NHS reforms, various means have been attempted to ameliorate the impact of the 'internal market' on teaching and research, including R & D funding. Yet the evidence to us was overwhelming that the pressures of service, and the pursuit of clinical research at internationally competitive levels, remain very difficult indeed to reconcile. Forms of governance which give greater weight to the academic mission of university hospitals, and service funding which enjoys some degree of protection, are needed if this country is to remain a leading centre of medical research." I think that is the briefest summary of our conclusions, but the conclusions do, of course, cover a considerable range.

3. You have analysed the medical schools' poor performance in the 1996 research assessment exercise and you found the scores of 21 out of the 38 "very disappointing". I wonder what sort of comparison you have about the grades which they achieved compared with the proportions achieved in other major disciplines and whether there was a significant change between 1996 and 1992? If one looks at the criteria used in the research assessment exercise, it would seem that virtually all the medical schools achieved at least a grade of 3, some 3A, some 4 and a few, very few, 5, but if one looks at 3, it is "research quality which equates to attainable levels of national excellence in a majority of sub-areas of activity or to international levels in some". Is that very disappointing?

(*Sir Rex Richards*) Disappointing, yes.

4. Would you like to comment upon comparisons with 1992?

(*Sir Rex Richards*) Yes. I would like to ask Sir Keith Peters to comment.

(*Prof. Sir Keith Peters*) My Lord Chairman, it is actually difficult to make direct comparisons with the 1992 exercise and, indeed, the Higher Education Funding Council has drawn attention to the fact that the rules of the exercise have changed somewhat, not least, of course, because the gradings altered between

the two exercises. For example, this time grade 3 was split into 3A and 3B and 5 had a 5* associated with it. If I could respond in a somewhat more subjective way as Chairman of a panel in both 1992 and 1996, my impression, I think supported by a certain amount of data, is that the fortunes overall of medicine have not changed very much, but it may be an opportunity at this stage to introduce what is behind the research assessment exercise. For example, the extent to which research income varies between the medical schools is now much greater than at any time in the past and there is increasing evidence that more of the medical research income from the medical charities is being spent selectively and, for example, there may be as much as an order of magnitude difference in the research income between our medical schools, sometimes even greater. I think rather than getting hung up on the RAE and its methodology, there are unequivocal data, which is the result of peer review in specialist subjects, which indicate an increasing divergence. One other point that is made in the report which is worth emphasising in the light of Sir Rex's opening statement is that it is clear that where institutions give their clinical academic researchers the right kind of opportunities, as for example exist in the postgraduate teaching hospitals in London, the performance of our medical researchers is well up to international standards, and I think the conclusion of the report, which is also substantiated by, as it were, everyday experience, is that we are asking our clinical academics to compete in many instances with one hand tied behind their back. That is reflected in the RAE, where, of course, it is the average result that is concluded by the Committee, and there are, of course, very large numbers of people in many medical schools who have job descriptions that result in a so-called long tail effect that brings down the average score.

5. Then you are satisfied, are you—and perhaps your colleagues would wish to comment upon this—that those who have criticised the actual nature of the research assessment exercise have really not made out their case, and as far as one can tell, the peer review system and the way in which it is conducted you would regard as being fair?

(*Sir Rex Richards*) Yes. We have seen no evidence to indicate that it is not fair.

6. You are nevertheless in no doubt that the clinical pressures of the NHS and the requirement upon many clinical academics to undertake more and more clinical work may well have impaired their research productivity and even perhaps their teaching?

(*Sir Rex Richards*) That is our view.

Lord Perry of Walton

7. Could I ask whether you could remind us of what the relative score in the pre-clinical departments in these universities was?

(*Sir Rex Richards*) No, I cannot give you that.

(*Prof. Sir Keith Peters*) No.

8. I could look it up, I am sorry.

(*Prof. Sir Keith Peters*) There are some specific examples which I could cite. For example, those departments or those universities which have termed biochemistry as a subject did very well and had very high scores indeed.

9. It is only that they have more time for research by comparison with their clinical colleagues.

(*Sir Rex Richards*) That is a hypothesis. We think it is very likely. We cannot prove that it is so.

Baroness McFarlane of Llandaff

10. Could I ask if the same arguments apply in dental schools? Is there the same clinical pressure?

(*Prof. Smith*) Yes, my Lord Chairman, the pressures are very similar in dental schools as in medical schools.

(*Sir Rex Richards*) Even greater, I would say.

(*Prof. Smith*) Yes indeed. I think that Table 7, which shows the information for dentistry, indicates that there were in fact fewer research staff submitted in the 1996 exercise, but ten of the schools increased their rating compared with 1992, and the outcome has been a 1 per cent reduction in funding for clinical dentistry by the HEFC.

Lord Flowers

11. My Lord Chairman, could I ask about other subjects? I have heard what has been said about the research assessment exercise as it applies to medicine, clinical medicine in particular, and I understand and sympathise, but much the same remarks can be made about any other subject perhaps, especially about the sciences or even more about engineering where the comparisons are perhaps in some respects fairly close. Can you say if there is anything particularly difficult about medicine as compared with other subjects?

(*Sir Derek Roberts*) My Lord Chairman, I would like to suggest two differences. Let me say that I am also very sympathetic to the problems which face all other disciplines. One of them—at the risk of stating the obvious again—is that particularly for the clinical as opposed to the pre-clinical academics, people individually and collectively are under pressure to perform research, to teach and to deliver service to the NHS. In engineering and the other areas of science they are under pressure to balance their teaching and their research, but there is not that commitment to provide a service component. So I think that is one difference. I think the other one, which impacts on the research assessment score which medical schools get, is that there is a commitment in a medical school to teach the whole of medicine. You would not think too much of a school of medicine which said, "Well, because we haven't got the capability to do good research in oncology, we therefore choose to omit oncology from the prospectus." So there is the commitment to teach the totality of the subject, to have people who are competent to teach the various areas of medicine, obviously to support the NHS through their appropriate contractual arrangements, and it is unrealistic in general for most medical schools to assume that across that full spectrum of subjects you

can draw together both the competence and the resources to do international-grade research. I think that to a degree that applies in other subjects where there are professional institutions to express a view in terms of the coverage, but there are many areas where a degree of selectivity and tuning the taught curriculum to the competence of the department is to some degree valid, but in medicine it clearly has no validity at all.

Chairman

12. Of course, in the other disciplines such as engineering, architecture and many others it has been customary for academics in the universities to undertake external consultancy work. Indeed, in architecture it has been a policy of the universities to require members staffing their department of architecture to engage in private practice. It used to be the case, of course, that academics in clinical medicine were precluded from private practice for personal gain. That has changed. Did you find any evidence to suggest that the ability of clinical academics to undertake limited private practice in any way impaired their research productivity?

(*Sir Rex Richards*) No, we did not. I think we would have found it very difficult to think of a way in which that could be demonstrated, but we have never had any suggestion made to us by a head of department or by a dean of a school that that was so. I think I am right in that.

(*Sir Derek Roberts*) Perhaps I could answer you, my Lord Chairman, on a purely anecdotal basis, because my experience is fairly limited. In the context of my own institution, as far as I can judge, most of the funds which are generated by the clinical academics doing private practice work are to the benefit of the research, because by and large these people plough them back into their soft income, they pay for a secretary and they pay to do all sorts of things which they are otherwise not funded to do.

Chairman] Thank you. That has been a long-term policy.

Lord Jenkin of Roding

13. I understood that that was a more or less universal practice, and that the change in the regulations made very little difference to the way in which consultants treat their income from private patients and do their research?

(*Sir Rex Richards*) Yes.

Chairman

14. You have suggested that the relatively poor performance in the research assessment exercise has been in part or perhaps largely as a result of the demands of clinical services and administration. You have suggested that vice-chancellors, deans and chief executives of NHS trusts should work together to address this problem in various ways. SGUMDER (the Steering Group on Undergraduate Medical and Dental Education and Research) was set up with the specific purpose of achieving that relationship between the universities on the one hand and the NHS on the other. Do you believe that that particular committee has functioned as well as it might?

(*Sir Rex Richards*) We can only see the effects, my Lord Chairman. As far as we can judge, it has not been particularly effective, but I do not know just what all the problems are.

15. You were kind enough to let me see a letter which was jointly signed by Alan Langlands and Professor Brian Fender from the HEFCE. That letter suggests that they are thinking of establishing joint task forces to examine this issue, following on your report.

(*Sir Rex Richards*) That seems very good news, but I know nothing about whether those task forces have indeed been set up or indeed what they are doing.

16. So you think this is something we ought to explore?

(*Sir Rex Richards*) Yes. It seems to me extremely good news, and one would hope that the collaboration between those two important departments might be improved.

17. I wonder whether you were able to identify any islands of excellence where medical schools and hospitals had managed to make satisfactory arrangements to protect research time?

(*Sir Rex Richards*) My Lord Chairman, if you look at table 3 at the band 1 institutions and, indeed, the band 2 institutions, these are the institutions where the RAE scores were 5 or 5*. You will see they include the Universities of Oxford and Cambridge, University College London, the Royal Free Hospital, the University of Edinburgh, University of Wales, University of Birmingham, and all the postgraduate medical institutes in the London area. We do think that those are institutions where they have been able so to arrange their affairs that the most talented research staff have been given perhaps more time than their standard five sessions a week for their research and teaching. I am afraid it is only qualitative but I am sure that those of you who are familiar with those institutions will recognise that that is so. The institutions which have scores of 5* are Oxford and Cambridge Universities and the postgraduate medical institutes.

18. Of course, technically your report was one commissioned by the CVCP and so you were not in a sense given the authority to pass on its recommendations to other bodies. So I take it that you have not been in touch with the NHS Federation? It is a matter which you are expecting the CVCP to take up?

(*Sir Rex Richards*) We have not been in touch with the NHS Federation but have had discussions with the CVCP. I was lucky enough to have an opportunity to go to Cambridge a week or two ago to talk to a group of chief executives of National Health Service trusts with medical schools. Not all the chief executives were there, but I did have a very interesting discussion with them. Unfortunately, I do not think any of them had actually read the report before I went to see them, but I talked to them about it and found them extremely supportive. There were two things I remember particularly. One was that

although improving the availability of consultants, so that academics might be required to do no more than their normal service agreement, has financial implications, they did not seem to think that that was the primary difficulty. What they were concerned about was the problem of finding the consultants, particularly in some specialties. That was one thing that I had not quite appreciated before. The other point that they made was that I had talked about the importance of the personal relationship between the postgraduate and undergraduate deans of the medical schools and the chief executive, and they all agreed that that was vitally important. However, the very high gearing of the research assessment scores to the income of the universities was throwing very considerable strains on those personal relationships. They also thought that the possibility of a university hospital trust was a very interesting idea. Those were the main points.

19. We shall come to that later. In the meantime, did you feel that the agreement that there should be a single university representative on all trusts controlling hospitals which had a teaching facility was an adequate representation?

(*Sir Rex Richards*) It is an absolutely minimal representation, it seems to me. I do not think it is adequate really, but the present position is that in some cases one does not even have that. The university representative in some cases is not even medically qualified.

Lord Jenkin of Roding

20. Of course, the problem that trusts face is that the size of their board is limited by statute. I was one of those who supported the amendment which insisted that a trust which included a teaching hospital should have at least one university representative. However, as you know, trusts and hospitals with associated teaching status have come under pressure from the universities but simply feel that such are the demands made on their independent directors that they could not cede one of the places to a university person. He or she might not be able to do all the other work that independent directors have to do such as chairing appointment advisory committees, and mental health care managers and all the other things they have to do.

(*Sir Rex Richards*) Yes, I understand.

21. Therefore, until the law is changed to allow an increase in the size of a trust board, is it not rather crying for the moon?

(*Sir Rex Richards*) Yes, I quite understand. The suggestion we make is a very complex issue, I appreciate that.

Lord Flowers

22. I would like to ask Sir Rex and his colleagues about money. Most of your recommendations involve money and mostly new money, as far as I can see. Your very first recommendation says: "Any increase in the target numbers for medical student admissions must be accompanied by a corresponding increase in the numbers of clinical academic staff and the facilities to accommodate them," and so on and so forth. Have you costed your proposals?

(*Sir Rex Richards*) No.

23. If not, why not, because if the money required to cover them is indeed fresh money and has to be fought for from the Government, a case has to be made point by point and one has to have some sense of priorities.

(*Sir Rex Richards*) We have not made any attempt to cost these proposals simply because we did not feel we were competent to do so. We are, after all, an independent task force. We had only one secretary. We did not have all the backing that one would expect in a proper government enquiry and we did not feel we were capable of doing that, and if we had attempted to get it done, it would have postponed the publication of our report very considerably and that I did not want to do. So I am afraid we have not costed it, and we appreciate that there are costs involved.

(*Sir Derek Roberts*) Could I add one thing on Lord Flowers' question relating particularly, as he said, to the very first of the recommendations, namely, that "any increase in the target numbers for medical student admissions must be accompanied by a corresponding increase", etc. What we were doing there was putting a stake in the ground on an issue of principle and saying, if the undergraduate population is going to be expanding, it should not be, as has happened in other areas over the last two decades, at the expense of quality, and that the unit of resource should remain constant. That can be quantified by anybody because the unknown parameter is by what number the number of medical students is going to be increased. If you want 1,000 more medical students in the country, then it is 1,000 times the existing units of resource. What we were anxious about was that when a policy does emerge in terms of the increase in the number of medical students, somehow they should not be plugged into the system on some sort of marginal costing basis which erodes the resource and the quality.

24. Please do not misunderstand me. I think all your recommendations are highly desirable and some are absolutely excellent, that one being one. Nevertheless, when the hard argument takes place with the Government, and that means the Treasury, you or somebody is going to have to have a very clear idea of what the costs of each recommendation might be and what the priorities amongst them might be, and if not you, then I presume the CVCP would be trying to do this?

(*Sir Rex Richards*) Yes. We saw ourselves primarily as a fact-finding enquiry and I did not feel that we had the backing or the competence to carry out an exercise of that kind.

Chairman

25. And for many years it has been a policy of government that the Department of Health should determine the country's need for doctors and that they have been the body that has controlled the number of admissions to medical schools and the consequential output. So presumably if it is the Department of Health's wish to have an extra 500

medical students to produce more doctors for the National Health Service, then it is going to be an issue that they are going to have to argue with the Treasury to see how that additional resource can be found?

(*Sir Rex Richards*) Yes, my Lord Chairman. What we feared was that, having found that the clinical academic staff are so hard-pressed as it is, if the numbers were to be increased without any additional staff or very inadequate additional staff, the situation would become much more serious; in fact, it might become very serious.

(*Prof. Sir Keith Peters*) I wanted to come in on Lord Flowers' question. Of course, it is well-known that the unit of resource for medicine has dropped substantially already, probably by about 40 per cent in real terms over the last decade. The second point which is worth making is that the number of medical students has already gone up by about 500 in the last five years. The third point that needs to be made in respect of the teaching responsibilities of clinical academic staff is that they now include to a much greater extent than hitherto the teaching of postgraduates in medicine as medical postgraduate training, quite properly, is becoming a much more structured activity. So these are a series of pressures against which any likely substantial increase in medical student numbers has to be considered. Of course, this will have to be properly costed and argued, that is clear, but where we start from is the position where there is really no sort of reserve at all to cope with the job expansion, as is evidenced by this report.

26. It has been an article of faith for many years that the university is responsible for postgraduate training of those who are studying full time for higher degrees, such as master's degrees and doctorates, with funding coming from the research councils and other funding agencies, but vocational training, postgraduate training for specialties in medicine, is the financial responsibility of the Department of Health. Is that something which is still accepted as doctrine?

(*Prof. Sir Keith Peters*) I have not heard it spelled out as clearly as that for some time. I think it is accepted as a principle, but the fact of the matter is that when you ask the question who is going to be responsible for delivering high-quality talks, lectures, seminars to postgraduates in medicine, increasingly it is the university staff who are the people who are most capable of doing that. This becomes a substantial further erosion on their time. Of course, it is worth pointing out that people do clinical academic medicine primarily, in my view, to do research. There are opportunities to teach which are fortunately available to NHS consultants in teaching hospitals and elsewhere, which can enhance their job satisfaction, and those are very important to the service, but the people who are the leaders of the profession originally get into the academic track to do research, and of course they are now being asked to do many other things as well.

Lord Jenkin of Roding

27. My particular perspective on this is having chaired a fair number of appointments advisory committees for consultants and having seen the quality of the candidates who have come before us. Some of them are senior registrars. Many of them have had an honorary senior lectureship which they have shared, and presumably their costs have been shared in the way that the Chairman described a moment ago. Some of them are in fact senior lecturers who have an honorary registrar post. All of them, virtually without exception, come with a long list of research achievements. One of the questions they always want to know of the trust is, will there be any opportunities for them to continue to do research in the job if they are appointed. The answer to that is "Yes, along with your teaching and your service requirements." I have not got the impression, from the candidates whom I have interviewed over the last six or seven years when I have chaired the committees, that there are people who have said, "Well I simply haven't had time to do any research, my service commitments have been too great". The list of their research achievements which they have put in their CVs has usually been most impressive.

(*Prof. Sir Keith Peters*) Perhaps I may respond to Lord Jenkin's remarks by making two comments. One is that I would suggest that in the majority of instances that research has been made possible because of the excellent research environment created by clinical academics who are professionals at doing research and are therefore in a position to take on registrars and give them the sort of training which leads to the kind of output which you have described, which I am sure is absolutely right. I think it might also be the case that you have been fortunate in having a not wholly representative experience, Lord Jenkin, in that clearly the kind of people who apply for teaching hospital appointments are expected to have substantial research achievements.

28. Yes, we are an associated teaching hospital at Whipps Cross, but it does attract some very high-quality candidates.

(*Prof. Sir Keith Peters*) Quite so.

Chairman

29. May I pursue another point of principle, because we have all talked for many years about the knock-for-knock agreement whereby the clinical services given by the clinical academics are supposed to be compensated for by the NHS consultants and other staff undertaking teaching and a certain amount of research. Following up the point made by Lord Flowers, this would imply that even university secretaries employed by the university should, under such an agreement, undertake secretarial work—writing outpatient letters and things of this nature—relating to clinical duties undertaken by clinical academics. Is this something which is now feasible or something which people no longer find acceptable in the present state of universities?

(*Sir Rex Richards*) I would not want to make too much of this, my Lord Chairman. All I can say is that we did come across some medical schools where this had been a very difficult problem. I can remember

quite a number of consultant academics saying that they found themselves writing letters to their GPs and to their patients in one day, and that did seem to us to be absurd, but I do not believe that this is a general concern. Nevertheless, it is not at all satisfactory, it seems to me. However, I would not want to make too much of it. My clinical colleagues will have more to say on that perhaps.

(*Sir Derek Roberts*) Could I make a slightly different point. I do not believe that the issue of secretarial support is likely to be a very big one. It is important to an individual where it applies, but I do not think it is a big issue. I think, though, you have raised a very important point in your question, because my own perception is that the principle of knock for knock was a very good principle, and that by and large it worked very well when both sides of that relationship felt that they were not under excessive financial pressure, but certainly from my own limited experience I do get the sense that knock for knock is something which is all the time now being questioned, when both parties are having to count the pennies and when issues like capital charges on space are being argued about, to transfer them from the NHS sector to the academic sector. So what was a very good principle, it seems to me, is creaking.

Chairman] One of the disadvantages, in some respects, which research workers in clinical medicine find in comparison, say, with their competitors in the United States is that in many medical schools in the USA the clinical academics will, for instance, spend three months of the year on-service, as it were, seeing patients, and nine months of the year they can devote to teaching and research virtually whole time. That never happens in the United Kingdom.

Lord Phillips of Ellesmere

30. Your report seems to suggest that funding agencies should step in when clinical research gets to a particularly critical point, and provide funds to relieve the researcher of some service commitment. I wonder whether you could elaborate on how you perceive that point?

(*Sir Rex Richards*) My Lord, it is not for us to tell the research funding agencies how they should spend their money. We have not put it quite so strongly as is implied in the question, I think. We have, however, proposed that they should consider seriously the possibility of doing this where it seemed appropriate. For example, supposing one has invested a very considerable sum in a major research project and then, as work is going along, one realises that the senior investigator is so pressed with other duties that he is not giving proper attention to the research or as much attention as he would wish. It seems to me that it would be only sensible to bail out some of his time and provide enough funds to appoint someone to do some of his other duties, so that he can apply himself fully to that particular project. It seems to me just a matter of sensible management of one's research funds.

31. So a funding agency may, for example, provide such a person with a senior research fellowship, part of the funds of which could be used to recompense the provision of service?

(*Sir Rex Richards*) Yes. On the question whether our group was divided as to the merits of part salary funding, I think the answer to that is no, we were not divided.

32. But your group obviously recognised very well the pressures on the funding agencies. I doubt whether you would be recommending that money for this sort of procedure should be transferred, for example, from the funding councils to the research councils?

(*Sir Rex Richards*) No.

(*Sir Derek Roberts*) If I can add a comment to this, some years ago, about 12 or 13 years ago, before I was involved with UCL I had a very happy period serving on the Advisory Board of the Research Councils under the chairmanship of Lord Phillips, and I remember an occasion then when I recommended that some serious thought should be given to the principle that is set out here, not specifically to deal with the issues of clinical academics but just that it seemed to me as a general principle that the leading researchers ought to derive some financial benefit. The reason I advocated this was that it seemed to me that we do put researchers in general—I am talking about academic researchers, not limiting it to clinical at all—into a situation where very often they have to make a choice, that if they do what the institution would like them to do and pursue research funded by research councils, medical charities, doing really good academic basic research, that is one thing. If, on the other hand, they choose to put their personal energy, time and enthusiasm into doing work of a different kind and maybe picking up consultancy contracts with industry, it does help pay the mortgage. It seems to me it is not really sensible in any management remuneration system to have a system in which the interests of the individual do not coincide with the interests of the institution. I do know that that issue is still being discussed again and some people are advocating that kind of change as one of the ways of injecting some new life into the issue of low academic pay in general by regarding the pay that people presently get as covering nine or ten months of the year and the active researchers getting a salary top-up out of their successful research fund applications. That is a very general point but it underpins the argument that is made specifically in the context of the clinical academics. Can I be forgiven for making one other point and that is that obviously, as Lord Phillips said, there is no such thing as a money tree and the money has to be found from somewhere and this is always the argument when one talks about the research councils or, indeed, the charities, funding things in a different manner. A personal opinion, but I think one which is fairly widely accepted, is that I would rather see a reduction in the volume of research that is being funded but see that work properly fully funded rather than be pretending that we are able to support a larger scope of work and do it in a manner which really causes long-term damage because it is not fully funded.

33. This system of funding agencies providing part salaries on grant support is very well-known in

Lord Phillips of Ellesmere *contd.*]

the United States and there is much experience of it there and I think we should be looking more closely at that. I certainly agree with him that we should be looking rather hard at the volume of research which is being supported in relation to the funds available for supporting it. There I am happy to agree with you. However, the funding of medical research and practice, viewed as I view it very much from the outside, is a very extraordinarily complicated situation. Is there any prospect, for example, of someone who is particularly successful in clinical research receiving a merit award in recognition of that? Does the existence of severe differentials in the remuneration of people involved in clinical medicine have any impact on the inclination of clinicians in academia in staying in academia or thinking that they would be much better, in view of their mortgages and so on, to move into clinical practice *per se*?

(*Sir Derek Roberts*) If I can give you my response—and I am sure you will get a better one from Sir Keith—I am not conscious of this as a problem. My experience is very limited and one reason is that, certainly as far as I am concerned, the leading clinical academics are eligible for merit awards. Also I believe that where we are talking about university staff, it is for the university itself to do something about this. For example, there have been circumstances where we have appointed somebody, particularly bringing people back from the United States, where, in the expectation that that individual would earn an A plus merit award in due course, we at University College have paid the appropriate salary on the basis that we would recover that as and when they won the award. So to some extent that is an option that the university management can exercise.

Chairman

34. That is, of course, a bit exceptional in the universities at present but would Sir Keith agree that whereas, under the old arrangement, it was often very difficult for the clinical academic with a good research career to get on to the C ladder, once they had got a C award they often moved quickly up through the higher merit awards, but nowadays, after the Kendell report, is it now easier for them to achieve merit increases and then to proceed up the merit award ladder than it used to be?

(*Prof. Sir Keith Peters*) My Lord Chairman, these are early days. We heard anecdotal evidence that it is now harder for clinical academics to have the equivalent of a C award than hitherto, but that is not fully substantiated, and where it is happening, or if it is happening on any scale, it has to be said that this is against the advice that is being given to trusts in respect of so-called discretionary points. It has been coupled, may I add, with a much clearer statement that it is possible for clinical academics to go directly to B awards whereas hitherto that was quite exceptional, but the extent to which this is happening is not yet clear. If I can pick up one point which Lord Phillips raised and which Sir Derek touched upon, I think there are particular areas of medicine where there is an internal brain drain because of the gap between the rewards that people can achieve by combining hospital with private practice. That seems to be the case in some branches of surgery and some branches of medicine where there are huge rewards to be made from procedural activities and, indeed, in anaesthetics as well. To some extent this undoubtedly, in these limited specialties, is a problem for the clinical academic community because even with the highest possible merit awards—and I think clinical academics do well on the merit award front at the higher levels—it is not possible to match the salaries that people are getting from a moderate amount of private practice. So I think there is a particular issue of surgery in all this.

35. To go back to the point that was raised by Lord Phillips' question, when he and I sat together on the MRC back in the 1970s the MRC created a number of senior clinical research fellowships for senior academics to be able to leave their appointments for a time and to undertake research; and, of course, the Wellcome Trust for years funded senior lectureships and also senior research fellowships in clinical science. Do appointments of that nature on a whole-time or part-time basis now exist or have they been discontinued?

(*Prof. Sir Keith Peters*) Actually they do exist. Interestingly, the uptake has been surprisingly small. The so-called senior research leave fellowship scheme for periods of three to five years is possible and, of course, the MRC also created other senior appointments for clinical research academics. The numbers of these in relation to, as it were, the needs of the system are very small. It is not wholly clear to me why the uptake has been so small. I think it is partly to do with the attitude of senior clinicians feeling that not only do they need to do clinical work but that it is an essential part of their standing in medical schools, and I think many would find it hard to give it up to do research even for a period of three to five years. Of course, in some areas, particularly those associated with technical skills, as in surgery, it is not only difficult to do it but it would be difficult to convince one's peers that one could return afterwards.

Lord Flowers

36. Could I ask Sir Derek another comparison question. You talked about merit awards and the like for clinical research staff. Many other university people, non-medical, earn consulting fees to quite a considerable extent, and some add very considerably to their salaries in this way. The mechanism is different, of course, but is there really any difference of outcome between somebody who gets recognised through the usual medical channel of merit awards and the like and somebody who gets recognised by contracts?

(*Sir Derek Roberts*) My Lord Chairman, I think that there is a difference, and it worries me. I think that the clinical academics, when they have the opportunity and they choose to participate in generating private earnings, are under more restraint than other areas. Let me be explicit in the case of University College. The system that we have at UCL is that other than in clinical medicine individuals are

nominally restrained not to spend more than about one day a week, subject to head of department approval. Whether, for that one day a week, they earn £1,000 or £1 million we really do not care—the more the better—it is the time which is controlled, rather than the earnings. Equally, I think it is fair to say that those earnings by and large are regarded as personal to the individual, but with the clinical academics there are two things which are different. The first one that I referred to is that there is a difference in behaviour, and a substantial part, if not all in many instances, of whatever earnings they get does go back into the departmental pot; but also we exercise a restraint not only on the amount of time but on the amount of earnings. This seems to me not to be wholly logical, and we are having some discussions about possibly changing this.

Chairman

37. Thank you very much. Of course, in a sense, this issue about the clinical academics leaving their service and teaching for a time follows on to the question which is raised by the new Calman arrangements for the training of specialists in the NHS, reducing the length of time. Many young clinical academics in training would be happy to accept an extra couple of years before they achieve a certificate of specialist training, but the question which is important to them is whether the number of national training numbers is adequate to take account of the needs of these young people training in clinical research.

(*Prof. Sir Keith Peters*) My Lord Chairman, there is no doubt that we are again in a transition phase between one system and another. The Committee heard clear evidence that people in that transition phase are quite disturbed about what they are now having to do. In response to pressure from the clinical academic community, a number of important concessions have been made which should make things a bit better, but there are some fundamental difficulties. For example, clinical research excellence is not, as we have already discussed, uniformly distributed up and down the country, and certain regions are excellent in research in certain subjects. It is quite reasonable, therefore, that young clinical academics in research fellowships should wish to go to the place where excellence—excellent research, excellent research training—is available. To take a particular example which I am familiar with and you are familiar with, we have an excellent department of neurology in Cambridge, which is attracting a very large proportion of would-be clinical researchers in neurology. However, the service in neurology which is needed for East Anglia is, of course, commensurate with the size of the region, which is quite small. This means that under present arrangements somebody emerging from a research training fellowship, say, having done three years worth of research, obtaining a PhD and having had his or her three years out, is now faced with the prospect of obtaining further clinical training. That further clinical training may not be available in East Anglia, because the numbers of posts are too few. This means that in order to continue clinical training—which of course is necessary—the person concerned has to leave the centre where the research is being done. We all know that in present-day research three years is just an introduction, and what happens afterwards is vital. This indeed has been recognised by the major granting agencies, the Medical Research Council and the major medical charities, by the creation of the clinical equivalent of post-doctoral positions or post-doctoral fellowships. MRC have clinician scientists, for example. Because of the constraints which I have talked about, it is now very hard to have this, as it were, seamless transition from the first research training fellowship into this next phase, because there may not be a clinical training slot available. This straightaway creates a discontinuity where somebody has got to move away from a place where he or she is best able to do the work, and where in the past there would be a system of interdigitation of clinical work and research work to allow continuity of experience. So that is a very important problem which would, of course, have been resolved by the provision of a small number of specific NTN slots, to allow this transition; the number is small because the number of people who, at the end of the three-year training period, elect to go on is very much smaller than those who take up a training fellowship. It would not have made any significant difference to the overall national planning of specialties. There is one other point which has been a source of great difficulty for clinical academics, and that is that if you are in a clinical training programme—a so-called specialist registrar, SPR—in the past it was customary, having gained experience of, say, two years in neurology, to identify a problem which was of interest to you, to find somebody who could supervise your research in it and take three years out, confident at the end of that time that you could secure another post; whereas now you can still take three years out and expect to enhance your professional standing; however the SPR posts are continuous, and you would be taking a chance on whether there was a slot which was freed up to which you could return. Also worrying is that the parent department losing the person from the training programme at the end of year two can only fill that by a locum, so there is a downgrading of a very powerful clinical training position. These are problems which are currently being discussed with postgraduate deans. Their general response is that in a steady state the people moving out of training programmes will be matched by people returning, and that of course might be the case. But that may or may not be the case and it would depend upon the kind of geographical variations that I have spoken about. So I think the Committee's mind-set was to say, "We want to see how this is working. There is this transitional problem and we reserve our right, as it were, to come back on this problem."

38. So does this imply that if a working group is established jointly by the NHS Executive and the HEFCE they should be made aware of the importance of consulting the Specialist Training Committee on this very issue?

(*Prof. Sir Keith Peters*) Yes, and, if I may add to that, my Lord Chairman, having academic representation on the Specialist Training

Chairman *contd.*]

Committees to a degree which is appropriate to the importance of the subject.

Lord Jenkin of Roding

39. I read this with some interest again, coming from the particular perspective which I have as the chairman of a trust with an associated teaching hospital, where you recommend in paragraph 8.2: "In any future changes, every effort should be made ... to reduce the number of NHS provider units relating to each medical school," whereas, of course, the trend has simply been in the opposite direction. Trusts are seeking to repatriate work, obviously in the context of the Greater London area taking it from the teaching hospitals in the centre so that the work can be done in hospitals closer to where people live, obviously not for tertiary referrals but for secondary, but this is helpful material for both teaching and research. It does seem to me that your recommendation would be a very difficult one if the result were to be that there would be fewer trusts or hospitals with associated teaching status. They would be then substantially downgraded and there would be very great resistance to this. If I could add one other fact in relation to teaching, the Royal Colleges, of course, have a very important role and in my trust recently we found ourselves making three additional appointments in surgery solely in order to be able to match the Royal College of Surgeons' requirements for teaching and there was going to be no additional service work because it would be shared among the consultants in question. But these mechanisms exist to maintain standards, to achieve a greater decentralisation and to bring work closer to where people live and their families, and it would seem to me that it would be very difficult to move in the opposite direction. I wonder if you would like to comment.

(*Sir Rex Richards*) Yes. There is a difference of emphasis here. We were not concerned with the question of the movement of research and teaching out into the district hospitals. That we understand to be very desirable. We were really more concerned with the managerial arrangements and the management of the personnel. We are concerned that the management of the national health service trusts and the universities together should take into account the total activities of the academics, but that does not necessarily mean that it need have any effect on the part played by district hospitals associated with the main trusts.

(*Sir Derek Roberts*) My Lord Chairman, I obviously understand very much the point that Lord Jenkin is making and certainly would not be advocating that all the district general hospitals that increasingly have a relationship should be brought into a single trust. That would be an absurdity. Let me give you the other extreme. Between the two extremes it should be possible to find ad-hoc ways of improving. I am sorry for being specific but in the case of the University College Medical School, which is the only case I know, it has been quite clear to me over the last many years that because not all, but the bulk, of our clinical teaching has been done in two Trusts, the Whittington Trust and the University College Hospital Trust, the scale of the impact on the financial affairs of those two Trusts of the SIFT income which they are given to cope with the teaching is such that if we decided for purely academic reasons that it would be sensible for the Medical School to move substantial numbers of the medical students from UCL hospitals to the Whittington or from the Whittington out to Chelmsford or somewhere, we could actually destabilise those hospitals financially with very serious effects. When you have that situation I think this leads to two things. It leads to the desire for a closer synergy or integration of management of the medical school of the university, on the one hand, and the associated hospital trust where there is that degree of financial interdependency, because we could do untold damage in the same way that the hospital could also do damage to the medical school if they chose to close down a whole department we were dependent upon for teaching. So there are two combined arguments, the one where you have geographic proximity, like UCL and the Whittington—and in due course the same argument will apply to the Royal Free as well—and where the SIFT income that those hospitals receive is a very substantial part of their income, and if we halved the SIFT income of one of those hospitals and doubled it in another by moving students that may well be academically justified but we would do untold damage to the NHS service provision.

Chairman

40. You therefore regret the fact that there is no university voice in the regional offices of the NHS Executive?

(*Sir Derek Roberts*) Absolutely.

41. Could I ask you whether you have examined the policy that certain medical schools have adopted of creating with NHS money chairs and senior lectureships in regional hospitals to try to produce nuclei of academic activity in those hospitals to aid in teaching and research?

(*Sir Rex Richards*) I am afraid we did not look at that.

(*Prof. Sir Keith Peters*) If I may make one observation on the issues to do with management in hospitals and trusts, one of the difficulties now is that whereas when regions existed it was usual for a very senior member of the medical school to be on the regional health authority, normally the dean or somebody of comparable seniority, that, of course, does not happen, as we have already mentioned. The authorities are not there for it to happen on. A subsidiary problem, therefore, is that if you are the head of a medical school dealing with only a relatively small number of trusts, as I am, I am only allowed to sit on one health authority. In my own case, I have chosen to sit on the principal purchaser authority. It means, though, that the person with the greatest seniority and weight cannot sit on the principal provider, because you cannot sit on more than one health authority. This means that there has to be a representative of the medical school or the university who must be different on each trust, and it is, of course, in my view, plain silly because there is

often only one person, or a small number of people who really know what is going on, who ought to be there to inform the trusts and the health authorities of the strategic intent of the medical school.

Lord Jenkin of Roding

42. I see the sense of that but it cannot possibly be done within the existing statutory constraints. It simply would not make sense for the individual trusts.

(*Prof. Sir Keith Peters*) I fully understand that too, Lord Jenkin. I am just saying that we have got ourselves, through legislation, into a situation where management is either made more difficult or, in fact, bad.

Chairman

43. So any significant change in governance, as Lord Jenkin has said, would require a change in the law?

(*Prof. Sir Keith Peters*) Yes.

Lord Jenkin] Primary legislation.

Lord Butterfield] Could Professor Peters sit as an observer on any of these other trusts, because his opinion might be valuable? He would not have any time to do anything else, I know.

Lord Jenkin of Roding] The remedy that we have adopted is that our clinical tutor sits on the committee that concerns itself with staff development and training and remuneration and he, of course, has very close links with the teaching hospitals, both with undergraduate and postgraduate research, and that for the moment has satisfied that element of our consultant body. One has to say it is not wholly satisfactory but it is a way you can do it. We are not limited by law on the number of people we have on our committees.

Lord Perry of Walton

44. I am attracted by the idea of a University Hospital NHS Trust and I would like to know what the pros and cons that you talked about were?

(*Sir Derek Roberts*) My Lord Chairman, I think it is fair to say that the committee would also like to know more about the pros and cons. What it was advocating is that more serious consideration should be given to this. As the starting point, I would suggest that there are three reasons for saying that more work needs to be done. The first is the issue which we have just been talking about, namely that we need to find some ways in which there can be a greater coincidence of interest and of management between key hospitals and the associated medical school. The second point is that there is some anecdotal evidence at least that this worked very well in this country in the past, like at the Hammersmith. Then the third strand which suggests that this is worth exploring comes back to a different topic we were discussing earlier, where Lord Phillips pointed out that when considering the extent to which research grants should include a component for salary, which is one of the things which happens in the United States, and we should see what we can learn from the United States. This kind of governance also seems, as I understand it, to operate in some of the major medical schools in the United States. If so it is a reason for saying that we should at least have a serious look at it, and that we should not assume that the degree of separation and fragmentation which is currently taking place is something with which we should assist. If I could make one final comment: there is a sense that as a result of further work the possibility of creating a new kind of Trust nationally must be considered. It does not have to be done across every potential circumstance in the country at the same time. We should be willing to perform experiments in terms of governance, just as we would perform experiments in anything else. So it may very well be that the only way one can really explore the pros and cons is to try it in one or two places and then be willing to extend it or close it down if the disadvantages outweigh the advantages.

Chairman

45. There is one very good example, for example, in Canada where the University of Western Ontario in London, Ontario, has that very form of governance. If I may give a personal example, in 1971 in Newcastle the Royal Victoria Infirmary, which had been the teaching hospital under a Board of Governors, gave up that independent status and a single university hospital management committee was created which embraced all the general hospitals in Newcastle and the psychiatric hospital under that single authority, with one-third of the members of the management committee being university representatives and the others representing the public in general. It worked, in my experience, very well indeed, until the 1974 reorganisation came along and changed it all by creating an area health authority, district health authorities and so on. So I believe there have been models in the past which can be looked at as a way of examining this proposal, but, as Lord Jenkin says, it would require primary legislation to change the situation. Let us turn to the very difficult issue of general practice. Do you have any solution? This is an issue with which deans of medical schools have wrestled for very many years.

(*Sir Rex Richards*) Yes, my Lord Chairman. We have no simple solution to this, and we appreciate that it is an extremely complicated issue. Nevertheless, it is perfectly clear from our enquiries that it is a very serious matter and a matter which requires very urgent attention. There is plenty of evidence that there is very great difficulty in recruitment of academic general practitioners, at a time when the General Medical Council is pressing for more care in the community and for more teaching in general practice. We have raised a number of issues in our report, but we did not really feel competent to prescribe any clear solution. The fact is that the Department of Health—and it seems to me to be very much the responsibility of the Department of Health—have really got to face this issue and try to find some means of making academic general practice more attractive. I am sorry, we do not have a simple solution.

Chairman *contd.*]

46. The universities can, of course, appoint professors and senior lecturers in general practice, but at the same time they have to be independent contractors of the NHS in order to undertake general practice, do they not?

(*Sir Rex Richards*) Yes.

47. Do you believe that the recent introduction of the salaried option for GPs under the recent Health Service Bill could conceivably make this any easier? It would still not overcome the problem of distinction awards, because it is the general practitioners in the profession who have opposed that principle, but do you believe the salaried option which is now available might make a difference?

(*Prof. Sir Keith Peters*) I think the principal issue is the distinction award issue. That has to be resolved by some system.

48. Perhaps the NHS should be asked to examine the new pilots now possible under the new NHS Act, to see whether this might in some way help to overcome this problem, at least in part. We can only say that this is a matter which clearly the Committee must think about and consider if they can see any potential solution.

(*Sir Rex Richards*) Yes. I am very sorry, my Lord Chairman, but we have not come up with any real solution to this. All we can do is draw attention to its very great importance.

(*Sir Derek Roberts*) My Lord Chairman, can I add one thing. It seems to me that there is one event which is taking place nationally, namely that great emphasis is being placed on evaluating the teaching of clinical students. An increased amount of that teaching is being done in general practice, and that will continue. Whether that will have an impact on the particular issue of recruitment into general practice depends on whether you are an optimist or a pessimist. The optimistic view is that when students have more exposure to good general practice they will recognise that it is just as intellectually demanding, if not more so, as some hospital specialities, and they will be attracted into it. The pessimistic view is that they will be so appalled at the conditions under which they see some things happening that they will say, "Not likely." There must, however, be more exposure of medical students to the good and bad features of general practice.

49. The Royal College of General Practitioners embarked on a scheme of trying to fund a number of research sessions for general practitioners, and as another part of the report of the Sub-Committee on Research in the NHS there was a recommendation that the R & D budget might be used in part to fund research sessions for general practitioners, so it could be that this combination of factors might make it a little easier in future, might it not?

(*Sir Rex Richards*) Yes, it might.

Earl of Selborne

50. Dental education is another area where you have drawn attention to what is clearly a very real problem, without being able, in terms of your brief, to come up with specific proposals. You say that you were struck by the similarities between the medical and dental academic professions. You go on to make a very clear case that the pressures on academic staff in dental hospitals are if anything greater than they are in the teaching hospitals, and of course that is exacerbated by the fact that dental students are expected to be competent to practise as soon as they leave dental school, which is in a sense just making the problem very much worse. Your recommendation at the end of 5.1.7 appears to be to have two separate enquiries, one a recommendation addressed to the funding bodies and the NHS Executive, and then a further recommendation that the whole of those concerned with dentistry in its widest sense and oral care should look at the future long-term arrangements. I wonder if you can elaborate on both those proposals?

(*Prof. Smith*) As Lord Flowers will know, the Nuffield Foundation has funded two enquiries into dental education, one in 1980 into dental education itself and the other in 1993 into the education of dental auxiliaries. I think the latter has led to increasing interest in dental auxiliaries and the possibility that their numbers will be increased, with the dentist being the team leader. The trends in oral health being such that prevention is much more to the fore, people are keeping their teeth into older age, and the dentist, as the team leader, is likely to concentrate much more on diagnosis, treatment planning and the complex aspects of treatment. That will be complex treatment and diagnosis for a more elderly population, one that has more medically compromised persons in it, one in which there would be many more of the population on medication, often multiple medications, and that indicates a greater link with medicine, both in terms of the teaching of dental students and auxiliary students and more opportunities for research at the interface between dentistry and medicine. Together with the fact that many dental departments in the schools are comparatively small, we saw that there were advantages to an increasing link between medicine and dentistry. Integration of the teaching of dental auxiliaries and dental students, and linking that into the necessary medical background they need, was behind one of the recommendations. It is also important, I think, in that context to think of the many different funding streams that there are that come into dental education. In the dental schools and teaching hospitals we have not only the teaching stream and the research stream of funding through HEFC auspices but we also have dental SIFT, we have medical SIFT for dental students, we have separate funding for auxiliary students, separate funding for postgraduate activities in dentistry and, of course, funding streams, often quite small, relating to the different purchasers of other treatment provided by the dental hospitals. It was because of those many different streams, all of which, or most of which, are actually directed towards the delivery and quality of education at the different levels of dentistry, that we thought it was necessary that there should be a careful look at whether they are too disparate.

Chairman

51. And when you call for a further enquiry are you suggesting that this is something that the CVCP should undertake, with appropriate membership of such a task force?

(*Prof. Smith*) Yes indeed, that would be a possibility. One of the things that the Council of Deans of Dental Schools has been trying to promote is that there should be a separate dental sub-group of SGUMDER, but it may be in the light of the fact that there will be this joint task force set up, as you indicated from the letter written by Alan Langlands and Professor Brian Fender, that that would be an appropriate area into which there should be dental academic representation to try and sort out some of these issues.

Earl of Selborne

52. Would it be part of the enquiry's remit to consider whether or not a pre-registration year should be introduced?

(*Prof. Smith*) I really do not think it would. I think that is more an issue for the General Dental Council to be interested in.

Lord Flowers

53. I have to declare that I am Chairman of the Nuffield Foundation. I am not quite clear what is being suggested. Nuffield has done two enquiries into dental education, as we well know. One was a long time ago and it was an enquiry into the education of dentists and I think the one more recently was about dental auxiliaries. Are you saying that the time has arrived when there should be another enquiry into dental education *per se*?

(*Prof. Smith*) I do not think, my Lord Chairman, that I would suggest that it should be of the same type of enquiry that the two previous Nuffield reports had addressed, but one in which bodies like the joint task force should take an interest, and like a dental sub-group of SGUMDER should take an interest, to look into the issues more than our committee could with one dental representative.

Chairman

54. So, Sir Rex, what happens now? Your report was, of course, commissioned by the CVCP. Have the CVCP Medical Committee had an opportunity of considering it?

(*Sir Rex Richards*) Yes, they have, my Lord Chairman. They met a few weeks ago and resolved on a number of actions and are going to reconsider the matter in six months' time to see what has actually happened. The Council of Dental Deans has produced an initial response to our report, and what we have come to know as CHMS, the Council for Heads of Medical Schools, has produced a draft response and I think they are trying to take some action. So the bodies with which we have been in touch are certainly considering the report and considering what action they can take. Unfortunately, many of the recommendations we made do require the co-operation of various bodies in the National Health Service and in the universities and it is not very easy to go through recommendations and just tick off the action that is required from each one. So it makes it all the more important that those two sides of the funding sources should work together, presumably through SGUMDER. I add the name SGUMDER because that is the body really responsible for co-ordination.

Lord Phillips of Ellesmere

55. My Lord Chairman, I understood Sir Rex to say that the CVCP would come back to it in six months' time. Does that argue the right sort of urgency to attach to this problem?

(*Prof. Sir Keith Peters*) There is a small group who are probably going to exert their greatest effect in due course on the task force which Alan Langlands' and Brian Fender's letter refers to. I think the Medical Committee also recognises that there are a number of joint actions that are required, and the point about the six months' time was not so much to sit on it for six months but to try and determine in the next six months that something has actually happened and that the report does not just sit gathering dust. That was the point about the six months.

Chairman

56. Would any of the panel care to add anything to what has already been said?

(*Sir Rex Richards*) Could I add one thing. In the report there is a description of an enquiry which was made by Stear and Goldacre on our behalf. They have conducted a further mailing of their questionnaire and now have about a 70 per cent response from all the different groups, which they regard as very good; the additional replies support the conclusions that are set out in the preliminary report that is attached to our report, and they are in the course of preparing a very much more detailed paper which will be published in due course.

Chairman] I can only add our sincere thanks to you for the enormous amount of work you have undertaken in preparing this report. It has been a most interesting exercise and one which we have found invaluable, and thank you for coming to talk to us today.

Supplementary notes by Sir Rex Richards

References are to the report of the CVCP Task Force

INCENTIVES AND REWARDS: PARAGRAPH 5.3

Most of the discussion on 3 November 1997 concerned senior academic appointments. However at the levels of Clinical Lecturer and Clinical Research Fellow, the issues are quite different. People at this level are trying to carve out a research career, are contributing to teaching and training, and are doing a considerable service load; at the same time they are themselves training for their CCST.

Research training now tends to take longer than in the past, and clinical academics see a sharply tapering career opportunity before them. There are comparatively few professorships, and they know that the standards required for that position are very exacting. At the same time academic doctors often get fewer ADHs allocated to them (and sometimes none), and we had evidence that there are many other small but discouraging differences in the remuneration they can receive compared with their peers following the normal NHS route to CCST. The difference can amount to as much as £10,000 a year at a time when young doctors have large mortgages and young families. We received anecdotal evidence that some particularly able young doctors had found the situation too discouraging and had abandoned an academic career.

By contrast, the career prospects for a Specialist Registrar are secure because the number of NTNs allocated is calculated just to fill the expected number of consultant vacancies; furthermore the "Calman" training scheme has made the route to a CCST significantly shorter than in the past.

MEASURES OF COMPETENCE: PARAGRAPH 6.4.1

The assumption that all trainees take the same time and require to undertake the same number of technical procedures to become competent and therefore merit "specialist registration" by acquisition of the CCST seems to us to be flawed. We appreciate that finding more flexible ways of assessing competence, which are nevertheless secure, presents difficult problems, and will require the collaboration of the STA, the Royal Colleges, Universities and Post-graduate Deans.

COLLABORATION: PARAGRAPH 5.1.13

Because medical and dental schools have to teach and provide training across the whole spectrum of disciplines, it is almost inevitable that some departments will be small and heavily burdened with service and teaching loads. However most modern research benefits from collaboration, or is, by its nature, multi-disciplinary. It is therefore not surprising that it is increasingly difficult for small departments to be at the forefront of research.

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